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AUTHOR Vittetoe, Marie; Hooker, Ellen
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ABSTRACT

Principles of performance based teacher education and humanistic education are surveyed, and both sets are found applicable and necessary for the preparation of health occupations teachers. The Health Occupations Teacher Education Program (HOTEP) of the University of Illinois/Urbana-Champaign is presented as an example of a program blending the two instructional approaches. Instructional problems basic to each of the theories are examined, and it is observed that reliance upon a narrow or single-minded philosophy of education will inevitably cause problems in developing fully competent educators. (MJB)

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Marie Vittetoe, Ed.D
University of Illinois, Urbana-Champaign

Ellen Hooker, Ed.D
University of Illinois, Urbana-Champaign

INSTRUCTIONAL STRATEGY GAP: THE COMPETENCY-BASED TEACHER EDUCATION (CBTE) - HUMANISTIC EDUCATION DICHOTOMY

1. Introduction

This paper presents an approach to teacher education which assists in closing the gaps between instructional strategies and the effectiveness of future teachers. The Competency-Based Teacher Education (CBTE) humanistic education dichotomy is a controversial but relevant topic. Case studies gained from experience with competency based education units/modules in teacher education will be used to illustrate the concepts discussed. It is hoped that this paper will stimulate discussion and motivate teacher educators to increase the data base in this area by conducting additional/related research studies. With increased data available, teacher educators could better develop or modify teacher education programs to meet student and societal needs.

2. Background

In 1970 an experimental model of a Health Occupations Teacher Education program (HOTEP) was initiated at the University of Illinois, Urbana-Champaign. This program was a response to the Vocational Education Act of 1968 which designated funding for secondary and post-secondary vocational programs, including health occupations programs. If more health occupations programs were to be initiated teachers would be needed for these programs. Therefore, HOTEP was designed to meet this need.

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Program development involved curriculum development, program promotion, and student recruitment. The HOTEP curriculum was included in the already existent teacher education programs for technical education specialties. In 1972, twelve HOTEP students enrolled in teacher education leading to a bachelor's degree. These students were credentialed, experienced health practitioners who had a minimum of 60 semester hours of college transfer credit. Using several teacher education courses, descriptive research on the effects of CBTE and humanistic education as opposing modes of teacher education will be discussed.

In recent years CBTE has gained many proponents due in part to the trend for accountability in education. The use of CBTE in turn fosters accountability, since each competence is measurable. The advent of increasing numbers of CBTE programs causes us to question--do our findings parallel previously reported research concerning the advantages or limitations of CBTE? How does CBTE compare with other modes of teacher preparation?

Background of CBTE/PBTE

In the early 1970's the American Association for Colleges for Teacher Education began to study performance-based teacher education (PBTE). Its Committee on PBTE commissioned a series of papers devoted to the antecedents, developments, and growing pressures which suggested that a reform movement of great potential was in the making. In the first of these papers written by Stanley Elam in 1971, performance-based programs were characterized by specified performance goals which were stated in advance of instruction. The students were to demonstrate either ability to promote desirable learning or exhibit behaviors known to promote it. Therefore, the student was held accountable for attaining a given level of competency in performing the

essential tasks of teaching rather than for achieving passing grades. In turn, the teacher training institution was held accountable for producing able teachers.[1] Elam suggested that the basic principle which emphasized "the demonstrated product or output" had, revolutionary implications for teacher education programs.

Elam defined terms related to performance-based vs competency based teacher education by citing Weber's and Cooper's three criteria for identifying compentency:

1) knowledge criteria (cognitive understandings of the student)
2) performance criteria (teaching behavior of the student)
3) product criteria (student's ability to teach as determined by pupil achievement)[2]

According to Elam, the term "performance-based" focused on performance criteria. However, the AACTE Committee on PBTE felt the adjective employed performance/competence was relatively unimportant as long as there was concensus concerning essential elements of performance-based or competency-based programs which distinguished them from other teacher preparation programs. In this paper, the terms CBTE and PBTE will be used synonymously as will the terms competency and proficiency. The two latter terms will be defined according to Houston and Howsam to indicate emphasis on the "ability to perform" rather than the "ability to demonstrate knowledge."[3]

The five generic essential elements identified by Elam that determine whether a program is performance-based follow. All elements must be present in order for a program to be categorized as PBTE by the AACTE Committee on PBTE.

1. The competencies(knowledge, skills, behaviors) to be demonstrated by the student are derived from teacher roles, made known to the student in advance, and are stated in such a manner as to permit evaluation of the student's performance.

2. The criteria employed to evaluate the student's competencies are based upon these competencies, are publicized in advance, and explicitly state what level of performance (mastery) is required together with specified conditions.

3. The competency is determined primarily in terms of student performance. Assessment criteria are based on the student's ability to plan, analyze, interpret or evaluate learning situations or student behavior. This assessment should be as objective as possible.

4. The student moves through the program based on demonstrated competency rather than by a predetermined time frame.

5. "The instructional program is intended to facilitate the development and evaluation of these student's achievements of competencies specified."[4]

In addition to the five specific generic essentials, Elam also identified six implied characteristics and seven related and desirable characteristics of PBTE. The implied characteristics state that instruction is individualized and personalized; feedback guides individual learning experiences; the program is systematic (systems approach); exit (not entrance) requirements are emphasized; instruction is modularized; and finally, the student is held accountable for performance.

Related, desirable PBTE program characteristics are: a field-based program; a broad decision making base; materials and experiences which focus on concepts, skills, knowledges for specific instructional settings;

student participation in instructional system design; a research component which is open and regenerative; professional education in terms of career education rather than preservice education; and lastly student role integration achieved through student teaching experiences.

This rather lengthy introduction to PBTE is essential for several reasons. First, prior to Elam's paper, PBTE had neither been satisfactorily conceptualized nor described. Second, most of the literature related to PBTE refers back to the definition and criteria of PBTE identified by Elam. Third, the content of this paper similarly refers to Elam's work, therefore, we have established a base from which the audience can move with us to explore the gap in instructional strategy between CBTE and humanistic teacher models.

Those of us who have received our education in schools of medicine, nursing, or the allied health are quite familiar with performance-based education because frequently our courses of study were written in terms of objectives. In the early 1950's this speaker served on a committee charged with the responsibility of standardizing hospital procedures for the University Hospitals, Madison, Wisconsin. This task was precipitated by the fact that each hospital unit performed precedures in its own way. The lack of uniformity complicated instruction of students and new personnel. That was my initial experience working with task analysis, behavioral objectives, and criteria (standards) of performance, etc. Those guidelines antedated Bloom's cognitive Taxonomy [5] by six years and Harrow's[6] and Simpson's[7] psychomotor taxonomies by nearly two decades. The authors' additional experience as practitioners and instructors in their allied health fields schooled us in the PB/CB methods, and we felt confident of the effects of this method of teaching.

Therefore, while the University of Illinois College of Education is not a PBTE institution, in conjunction with other HOTEP faculty we developed some competency based units/modules within our courses. Our experiences with PBTE have made us somewhat cautious about where and how to use PBTE in the program.

We would like to share some reflections of our experiences as well as some experiences reported by our students. Case studies will revolve around: (1) how to assess competency; (2) difficulties students experience when they try to synthesize learning experiences; (3) limitations of simulated experiences; and (4) the students' need to interact with each other while learning.

Level of Competency

A major problem we have faced, and continue to face, concerns determining when a student has achieved the specified level of competency. In sequenced courses such as curriculum development, teaching methods, and cooperative education, we use units/modules which we or others have developed. For example writing instructional objectivesis in curriculum development, lesson plans in teaching methods, etc. However, students are pretested/retested on behavioral objectives at the beginning of the methods course.

We have developed criteria to assist us in evaluating students performance in writing and critiquing objectives. It disturbs us to discover that while some students can meet the performance standards for individual competencies they do not employ these competencies in working on modules for which they are prerequisites. Let me elaborate.

Units in the methods course include: writing and critiquing objectives; developing lesson plans; microteaching; constructing and critiquing: 1) individualized programmed instruction (IPI) learning packages, 2) classroom tests, and 3) clinical evaluation forms. Written instructions state that behavioral objectives shall be used in lesson plans, microteaching, IPI's, clinical evaluation forms, etc.

A student may demonstrate competence in units on writing and critiquing behavioral objectives and yet fail to write behavioral objectives for lesson plans, fail to include objectives in IPI's, and fail to critique clinical evaluation forms for objectives.

Even more disturbing to us is the inability of some students to relate instructional content from one course to instructional content in succeeding courses. Why will a student who has utilized behavioral objectives to meet competency requirements in the curriculum development course start at base zero when beginning the methods course? We seem to be experiencing this stiuation more frequently each time the methods course is offered. Students hand in materials and expect to recycle them until they achieve the minimum level of performance. This fall when I taught the extramural methods course, the number of recycled papers increased each week until finally for the last assignment, nineteen of twenty seven students recycled assignments! Discussions with instructors who utilize programed instruction in teaching science courses reveal they have had similar experiences with students repeatedly recycling units of study. This became such a serious problem at one community college that some instructors have been forced to change their method of instruction.

How then, should we assess competence? Should we rate a student competent in writing behavioral objectives or developing set induction when s/he completes the first unit/module satisfactorily? Or should we wait to make assessments of these competencies until students demonstrate their ability to incorporate them into subsequent learning experiences?

Difficulties Students Experience When They Try to Synthesize Learning

This experience with recycled assignments appears to us to be a manifestation of the inability of students to integrate and apply principles from preceding competencies into subsequent assignments. Students focus on one detail or another rather than assimilating the totality of the assignment. For example, assignments dealing with set induction to facilitate learning do not appear to be carried over by some students into their lesson planning. Students proceed through a sequence of assignments related to set induction. They read about set induction, develop examples of set induction, and critique examples of set induction. Yet when the microteaching sessions are videotaped, there will always be students who start their lessons with a comment such as "students, today we are going to talk about..." This occurs despite the fact that the written lesson plan for the microteaching session has a perfectly good set induction outlined!

We have had students, then, who seem to handle the bits and pieces of the educational puzzle but who are unable to put the pieces together. Do we program students to focus on pieces of the picture puzzle rather than on constructing the complete puzzle when we break learning down into modules that focus on the pieces rather than the whole?

Recently we received an order form and a sample module from the series of 100 modules developed by American Association of Vocational Instructional Materials (AAVIM) PBTE materials.[8] Each module focuses upon teacher competencies which were identified through research as important to successful teaching at both secondary and postsecondary levels of instruction. The foreward discussed how these field tested modules integrated theory and application, criterion referenced assessment, flexibility, etc.

I have in my hand, modules B-5 and B-6 titled Select Student Instructional Materials and Prepare Teacher-Made Instructional Materials. No instructor would necessarily have to use all 100 modules. The $1.30 to $4.00 price range creates the illusion that the materials are inexpensive. They are not. In fact they are very expensive. Modules range in price from $1.30 to $4.00. The total cost of 100 modules is $237.50.

The Illinois Office of Education financed the development of a series of 64 POP Kits (Pre-Service Occupational Program modules or individualized learning packages)[9] similar in concept to AAVIMS, and covering virtually the same content. We participated in the field-testing of some of the POP Kits and continue to use them in some of our courses. One need only look through instructional materials catalogues to become aware of numerous similar types of PBTE materials from which to choose. One wonders whether a set of 100 competencies is better than a set of sixty-four, particularly when no universally accepted list of teacher competencies exists (Rosenshine[10]).

Some students like to use the competency-based modules, others do not. If this is the case, is it possible that PBTE programs attract some types of students while repelling others? We have the uncomfortable feeling that

this may in fact be the case. I cite the following instance as evidence. One of us taught a curriculum development course off-campus a year ago. When the course outline was handed out students were told it could be modified to meet their needs. The students' response was in essence: 'Look, just tell us what it is you want us to do. Don't ask us to help decide what the objectives of the course will be. Tell us what you want, and we'll do it!' These were "adult learners!"

This concern relative to the inability of students to assemble pieces into a complete whole has been expressed since the inception of PBTE. Broudy wrote:

> I shall devote little space to the assumption that in teaching the whole is merely the sum of the parts. This is a notoriously inadequate description of any human action, let alone one so complex as teaching. Teaching can, of course, be <u>thought of</u> as broken down into parts, but as a concrete action it is guided at every moment by a sense of its total pattern. This pattern -- in swimming, reading, classifying, judging -- integrates the analyzed constituents into a meaningful functional sequence, not merely a mechanically additive one . We are told, at least by some psychologists, that <u>after</u> the pattern has been sensed or felt or understood, the details can be perfected separately, but until the pattern has been discerned, drilling on the separate parts yields disappointing results.[11]

Apple[12] expands on this concept in his critique of PBTE models -- in particular the Massachusetts Model which refers to Polanyi's study. Polanyi noted that human experiences and feelings were more than the parts.[13] Apple speaks of "atomized" behavioral elements and bite-sized behaviors. He, like Broudy, disputed the assumption that atomized elements of behavior or knowledge are additive. He also noted that PBTE models fail to deal effectively in integrating bite-sized behaviors into

"significant clusters of behavior."[14] Our experiences would tend to corroborate these statements.

Limitations of Simulated Experiences

Closely related to the problem we have experienced with students not synthesizing sub-unit content within and across units are the problems students experience in attempts to extrapolate integrated behaviors developed in classroom or laboratory simulations into the clinical area. One of our master's degree candidates L.S. who teaches medical laboratory technicians (MLT) in a community college described the difficulty her students faced when they started to draw blood samples from humans after having perfected their phlebotomy techniques on "phantom limbs" in the simulated lab. Although they could insert needles through latex skin, subcutaneous tissue and vein walls to withdraw siumlated blood from a simulated vein, many panicked, or became faint, or forgot the procedure when they attempted the task on a living person.

While they had practiced the procedure in a "simulated gestalt" setting, moving to a "real gestalt" setting proved to be the undoing of students previously thought to be competent. L.S. added a transitional experience to follow the simulation before sending students into the clinical area. Students were assigned in pairs to draw blood from each other. The students then discussed their reactions to each of the roles they had assumed.

What appears to be surfacing in situations such as that just described is an awareness by students of the interrelationships which exist among the domains of learning. During much of PBTE instruction, learning behaviors are dissected in such a manner that each of the four domains with which we deal is presented as a separate entity. In fact for learning

purposes we may require the student to deal in one domain at a time to the exclusion of others. In reality, the domains are intricately interrelated.

Because so much of the content in medicine, nursing, and allied health deals with perceptions, we have included content dealing with the perceptual domain (Moore)[15] in addition to the cognitive, affective, and psychomotor domains. We have also elected to use the Pierce-Gray taxonomy[16] for the use in the affective domain rather than Krathwohl's taxonomy[17] and the Hauenstein[18] taxonomy for use with the psychomotor domain rather than Simpson's[19] or Harrow's[20]. The selected taxonomies seem to be more appropriate and adaptable to the needs of health occupations education students. The hierarchical progression of the Pierce-Gray and Hauenstein taxonomies are more consistent with Bloom's[21] cognitive taxonomy.

When the MLT's move into clinical practice, they have to deal with affective and perceptual behaviors they did not experience in the simulation labs. They realize that drawing blood inflicts pain upon another human being. Real blood is different from simulated blood. MLT's have to interact with patients while carrying out the procedure. They also have to interact with other hospital personnel and are required to do this in a variety of settings. Consequently, they focus their attention on factors other than those which were present during the "simulated gestalt" setting. In effect, the MLT's need to develop competency in a "new" procedure under a "new" set of circumstances. To return for the moment to our picture puzzle analogy, this is what we perceive has happened. The student has been able to assemble the pieces into the completed picture puzzle. However, the picture lacks stereoscopic depth. Therefore the picture can not equal the scene it depicts.

Hauenstein has depicted this interrelationship of the domains. The section which follows is based on Hauenstein. The Pierce-Gray domain of affective behaviors has been substituted for the Krathwahl domain. Also, the perceptual domain described by Moore has been added to the model. Inherent in the psychomotor functions vector is the notion that humans do not merely act but act in accordance with their intellect and emotions.[22]

A psychomotor behavior classified at the level of manipulation would, according to Hauenstein, have attendant cognitive (application) and affective (validation in the Pierce-Gray taxonomy) abilities of the individual which could be inferred. Adding the perceptual domain to Hauenstein's model, attendant symbol perception abilities of the individual could also be inferred.

The curriculum, then, should provide experiences which permit the student to develop desired behaviors. First, the student should be allowed to perceive (establish referents), imitate (repeat the task or skill), manipulate (practice the task or skill), perform (utilize the task or skill in a variety of settings), and perfect (refine) his/her behavior in accordance with his/her cognitive and affective ability. Furthermore, it would be possible to identify deficiencies in a student's cognitive and perceptual, and affective behaviors by comparing his/her psychomotor performance to specified cognitive, perceptual, and affective performance objectives.

However, not all behaviors on the psychomotor vector would necessarily have cognitive, perceptual, or affective behaviors at the same level. The psychomotor vector might fluctuate toward the cognitive, perceptual, or affective axes in relation to forces attributed to the cognitive, perceptual, or affective development of the student. Thus, for behaviors with high

cognitive development but low affective development, the vector would be drawn toward the cognitive functions axis. In turn, the affective axis would be shortened. Conversely, the vector for high affective development but low cognitive development would be drawn toward the affective axis with the cognitive axis shortened.

Hauenstein cautions against expecting students to perform at a level for which they lack development. That is, after having demonstrated a procedure, --the students are at the perceiving level -- students will become frustrated if they are expected to perform the procedure without permitting them time to move through the imitation and manipulation steps. We suspect this may be what happens when students are unable to utilize competencies they have supposedly mastered. They may not in fact have had sufficient time to imitate, manipulate, and perform in the module, before being expected to incorporate these competencies into larger components.

In addition, students must be able to work between the domains. They must perceive stimuli (perceptual domain) respond to these stiumli (affective domain), know what course of action to take (cognitive domain), be willing to act (affective domain), and then act (cognitive or psychomotor domain). So, providing students with cognitive skills without relating these skills to the affective, perceptual, and/or psychomotor behaviors may in fact be programing them to fail. Cognitive and psychomotor skills require the affective and perceptual cement to integrate the bite-sized or atomized behaviors, to which Apple referred into "significant clusters of behaviors." The psychological foundations of humanistic education which we will discuss next are inherently different than for those of PBTE.

Humanistic Education

The origins of humanistic education may be found in Aristotle. His influence was also found in the teaching of later writers, such as Thomas Aquinas, Comenius, Locke and Rousseau.

Most of the recent experiments such as Summerhill[23] and other British school experiments, in humanistic education have involved children in the lower grades. Humanistic education experiments have revealed that students will often set their own goals or learning objectives. Frequently there are no examinations and no grades are given other than those which would indicate the student has performed successfully. These courses culminate with pass-fail grades. A great controversy has ensued over this method of grading, especially when these students' grades are evaluated for college entrance or graduate school requirements.[24] (Patterson p.44).

Teachers in this atmosphere must possess certain qualifications in order to fully develop this one-to-one relationship. Various psychologists have attempted to set these teacher student inter-relationships into perspective. B.F. Skinner,[25] a behaviorist, believes that teachers should use technology in order to allow them to deal with students on a more personal basis.

One's educational philosophy somewhat determines one's behavior in the classroom.[26] If one believes that man is reactive to determiners in his environment then it follows that man is not in control of his destiny but rather is controlled by external forces. However, if one believes that man controls or creates his own world, then it follows that one believes in free will. One has freedom to make choices in the process of "becoming." Once these choices have been made one is responsible for the actions which follow.

Humanistic education is rooted in the Third Force or perceptual psychology which attempts to develop an understanding of the self. According to Combs a professional teacher's behavior is based on the "self as instrument" concept.[27] This is an opposing view to that of the behaviorist or stimulus response psychology on which competency-based education principles are based. The humanistic approach to education focuses on the growth and developement of the student with the teacher acting as the facilitator of this growth process.

According to Combs this means that the human being at any given moment behaves (1) as the result of the way in which the person perceives self or (2) how the self utilizes the present situation or through an interrelation of these two behaviors. For example, if a person is in the student role then that person will act out being a student or if the person is in the teacher role then concomitant behaviors will result. Thus in perceptual psychology "to change another person's behavior it is necessary somehow to modify beliefs or perceptions. When the individual sees things differently, s/he will behave differently."[28]

Patterson explains "there are two aspects of humanistic education. First, there is that of teaching subject matter in a more human way. That is, facilitating subject matter learning by students. The second is that of educating for non-intellectual or the affective aspects of the student. That is, developing persons who understand themselves, who understand others, and who can relate to others.[29] Furthermore he claims that if students do not perceive education as valuable, then they are no longer motivated to learn those things which they believe to be of no value. Therefore, one of the teacher's most important functions is to convince students that what is being taught is relevant.[30]

In health occupations education, a problem of dissonance ensues when humanistic approaches are employed. Medicine and the other healing arts are rooted in the sciences. The sciences are deterministic in nature. Therefore, this concept of freedom inherent in humanism appears to be in direct conflict with the determinism expressed in science. Those who teach doctors, nurses, and members of the allied health professions deal with students whose initial educational preparation has been oriented toward science courses. Consequently, students tend to view their professional roles in deterministic terms. Traditionally it has been difficult for them to make the shift to a humanistic mode when they leave classrooms and laboratories and begin the clinical phases of their education. To overcome this dissonance between determinism and humanism, we have attempted to bridge the gap by involving students in group process and internships where they have opportunities to interact with each other and with patients.

Various authors such a Combs, Rogers, and Patterson have researched counseling as well as the teaching-learning process and report a number of qualities necessary for effective learning. They include empathy, respect for other human beings, and genuineness. These same qualities are essential to the practitioner-patient relationship.

Qualities of Humanistic Education

Patterson suggests that there are three conditions necessary for humanistic learning environment: empathy, respect, and genuineness.[31] Empathy implies understanding another person as though one were "wearing the other person's shoes." This characteristic has been inculcated in the roles of doctors and nurses for centuries. Recently the education of

health occupations personnel has attempted to inculcate all health occupations personnel with this empathic consideration of the patient. This empathic consideration implies that health workers try to understand the patient so that patient care can be planned to involve the patient's perception of self as well as the health care workers' perceptions of themselves in relation to the patient.

Another characteristic of a humanistic attitude is respect for other people. Respect implies that teachers or practitioners accept students or patients as they are rather than in preconceived terms. Therefore, the individual who is uncouth, dirty or unshaven, from another social, ethnic, age, or religious group is respected and accepted as a person.

The third humanistic characteristic is genuineness. Somehow students and patients can tell when teachers or health care workers are sincere. Here again the health care workers, in particular the physicians and nurses, have known that the patient responds best when the relationship between them is genuine and open. Modern psychology classifies this interaction as a facilitative relationship, whereby the teacher or healer who is genuine or sincere, is able to elicit "freeing" of the student or client encountered so that either learning or healing takes place.[32] In the classroom this implies that there are no threats. Student and teacher can engage in frank, open conversation and relationships. The student is not subjected to laughter or scorn for responding either incorrectly or inappropriately. Similarly, in the practitioner-client relationship, openness is essential. Patients are encouraged to discuss their illnesses and perceptions related to their illnesses with doctors, nurses, and allied health personnel. Patients' attitudes and perceptions are incorporated into plans for their care and treatment.

According to research studies this facilitative roles open new horizons for students and leads to many behaviors which would not otherwise surface. The facilitative role also opens new horizons for patients and leads them to behave in new and different ways. This brief summary of the theory underlying the principle of humanistic education points out the importance of the teacher's educational philosophy as a major determinant of the teacher's behavior.

Implementation of Humanistic Education

We now turn to the role of the teacher-educator in implementation of the humanistic education process. In order to develop the qualities of humanistic education, teachers must learn to listen and to respond. If they do not hear or see through verbal and non-verbal communications, what the students are "saying", they will not be able to respond appropriately or adequately. Mutual listening and responding with understanding is sometimes classified as an encounter. Encounter as defined by Patterson, requires a highly personal, genuine and meaningful relationship. Such a relationship is rewarding and enhancing both for individuals or for members.[33]

Earlier we discussed the matter of perception and expectation. A phenomonon known as the self-fulfilling prophecy exists. The implication is that when we do not expect people to perform well, they do in fact perform poorly. Conversely if we have high expectations for people they will try to meet these high expectations. Combs reported that good teachers tend to be more sensitive and concerned about people and their reactions rather than about things or events. As would be expected good teachers have good perceptions of themselves such as adequacy, trustworthiness, being wanted and identifying with others.[34] Implications for teacher education programs appear to be quite obvious.

In order to teach the students to become good teachers one must involve the student in learning more about self and self-concept. Even more critical is getting the student in contact with other students. To facilitate this particular aspect of teacher experience we have dealt heavily in this humanistic process. Our classes have attempted to bring students together in group discussions, group critiques, and group projects. In the Health Occupations Teacher Education Program we have approximately 25-30 students per class. Students in these classes may represent as many as 6-10 different health occupations. Students also come from varied backgrounds with respect to the size and type of school from which they graduated, section of the country from which they originated, and whether or not they are recent graduates from allied health programs or have as many as 20 or 30 years experience as practitioners and/or teachers. This indicates the tremendous range of age as well as experience our students bring to us.

Because of these wide variations of experiences, students in group process can facilitate the learning process. These interchanges among peers obviously are part of the growth concept as purported by Combs. We have deliberately tried to vary small group structure by assigning as many different health occupations practitioners as possible to each group. We also attempt to assign one student "facilitator" to each group. This facilitator is perceptive to the needs and characteristic attitudes and behaviors of group members. She/he then knows which participants adopt negative or positive approaches to topics under discussion. She/he also recognizes which students have had little or no group experience and consequently attempts to involve them in the group process.

Our own backgrounds as health professionals who have dealt not only with patients for years but who also have been involved as educators both within our own allied health fields and as health occupations teacher educators has heightened our awareness of the importance of the development of self-concept. Therefore we are attempting to improve the role model process in learning. Modeling is one of the major ways in which people learn. For example, students will observe a teacher employ a teaching strategy, interact with students or engage in research. Through this modeling experience students will determine whether or not to adopt similar teaching strategies, patterns of interaction, or participation in studies to advance the art of teaching. Similarly, students can pattern their actions on actions of their peers -- their fellow students. Role modeling may be either conscious or unconscious. Unfortunately, individuals can pattern their behavior upon undesirable role models as well as desirable role models. Imitation has been utilized as an instructional method in education since time immemorial. Even young animals have been observed to imitate their elders. This modeling process has long been recognized as effective by parents as well as educators in teaching attitudes.

Apprenticeships, preceptorships, and internships are all examples of the modeling process -- as is student teaching. Hopefully student teachers will be placed with model teachers who can assist them achieve role integration. Teacher education is crucial and challenging because in the process of teaching subject matter, the teacher's attitudes and behaviors have the potential to shape the students for better or worse. In the health field where students must be aware of and responsible for their relationships and interrelationships with patients, families, and other staff members, the ethical aspects of teaching are critical. Acts of omission can serve

to shape student attitudes and behaviors as well as acts of commission. Therefore the development of the neophyte health occupations students is extremely important because as future health occupations teachers they will be responsible for teaching health care workers.

If those advanced skills which are required in the health care field are incorrectly imparted or if attitudes associated with clinical practice are not fully developed serious consequences may result. Furthermore, the effects of poor teachers of future health care workers may be perpetuated.

For this reason teacher education programs for health occupations students should not be left to chance any more than education programs for elementary or secondary school students should be left to chance. Until recently the preparation of teachers for health occupations had not been planned. It was assumed that the good practitioner would make a good teacher. When instructors for allied health programs were needed, practitioners were selected for a variety of reasons - usually none of which was related to teaching -- such as level of educational preparation, length of service in the field or even for "political" reasons. As a rule teaching assignments were made without the individual having any previous experience or theoretical preparation. In addition, assignment of practitioners to roles as teachers was often done without consulting them. It was precisely to overcome this situation of non-teacher prepared practitioners teaching in medical, nursing and allied health programs that such programs as the Health Occupation Teacher Education Program at University of Illinois have been initiated in many parts of the country.

Summary

In summary we feel that both PBTE and humanistic education are applicable in the preparation of health occupations teachers. For example, curriculum development and teaching methods classes take full advantage of assignments requiring competence in each unit before proceeding to the next unit. There is also a minimum criterion level which must be met before completion of a course. In other areas of curriculum, such as the trends and issues courses, and the student teaching component, students are encouraged to develop individually, through group process in the classroom and then in the school settings. Since there is no "one way" to teach, students are encouraged to develop their philosophy of education and implement this philosophy through teaching experiences. Therefore we have attempted to show how we have developed and continue to develop a teacher education program that blends competency-based education and humanistic education.

There appears to be no simple way to eliminate the dichotomy between competency-based education and humanistic education. We have found that both types of education are essential in developing a well prepared teacher of health occupations. We are convinced that the effects of the reported observations are equally applicable to other teacher education programs. We originally intended to develop a PBTE program but our experiences with CBTE models did not bring role integration, therefore we have modified our opinions. Consequently, we have blended the PBTE with humanistic education approaches. We view with concern the increased emphasis being placed on PBTE to the exclusion of other methods of preparing teachers by state departments, colleges, schools and departments of education.

It would be ironic indeed if the PBTE methodology which developed partly in response to failures of traditional teacher education programs to meet individual student differences (Hunt)[35] resulted in educational programs in which students were faced with a single teaching-learning method-PBTE. In health occupations and in fact in all teacher education programs educators must, at some point, recognize the problems which will ensue if we apply a narrow or single minded philosophy in developing programs of teacher education.

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